

## § 156.105

in any of the three largest small group insurance products by enrollment, as defined in §159.110 of this subpart, in the State's small group market as defined in §155.20 of this subchapter.

(2) *State employee health benefit plan.* Any of the largest three employee health benefit plan options by enrollment offered and generally available to State employees in the State involved.

(3) *FEHBP plan.* Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by aggregate enrollment that is offered to all health-benefits-eligible federal employees under 5 USC 8903.

(4) *HMO.* The coverage plan with the largest insured commercial non-Medicaid enrollment offered by a health maintenance organization operating in the State.

(b) *EHB-benchmark selection standards.* In order to become an EHB-benchmark plan as defined in §156.20 of this subchapter, a state-selected base-benchmark plan must meet the requirements for coverage of benefits and limits described in §156.110 of this subpart; and

(c) *Default base-benchmark plan.* If a State does not make a selection using the process defined in §156.100 of this section, the default base-benchmark plan will be the largest plan by enrollment in the largest product by enrollment in the State's small group market. If Guam, the U.S. Virgin Islands, American Samoa, or the Northern Mariana Islands do not make a benchmark selection, the default base-benchmark plan will be the largest FEHBP plan by enrollment.

### § 156.105 Determination of EHB for multi-state plans.

A multi-state plan must meet benchmark standards set by the U.S. Office of Personnel Management.

### § 156.110 EHB-benchmark plan standards.

An EHB-benchmark plan must meet the following standards:

(a) *EHB coverage.* Provide coverage of at least the following categories of benefits:

- (1) Ambulatory patient services.
- (2) Emergency services.
- (3) Hospitalization.
- (4) Maternity and newborn care.

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(5) Mental health and substance use disorder services, including behavioral health treatment.

(6) Prescription drugs.

(7) Rehabilitative and habilitative services and devices.

(8) Laboratory services.

(9) Preventive and wellness services and chronic disease management.

(10) Pediatric services, including oral and vision care.

(b) *Coverage in each benefit category.* A base-benchmark plan not providing any coverage in one or more of the categories described in paragraph (a) of this section, must be supplemented as follows:

(1) *General supplementation methodology.* A base-benchmark plan that does not include items or services within one or more of the categories described in paragraph (a) of this section must be supplemented by the addition of the entire category of such benefits offered under any other benchmark plan option described in §156.100(a) of this subpart unless otherwise described in this subsection.

(2) *Supplementing pediatric oral services.* A base-benchmark plan lacking the category of pediatric oral services must be supplemented by the addition of the entire category of pediatric oral benefits from one of the following:

(i) The FEDVIP dental plan with the largest national enrollment that is described in and offered to federal employees under 5 U.S.C. 8952; or

(ii) The benefits available under that State's separate CHIP plan, if a separate CHIP plan exists, to the eligibility group with the highest enrollment.

(3) *Supplementing pediatric vision services.* A base-benchmark plan lacking the category of pediatric vision services must be supplemented by the addition of the entire category of pediatric vision benefits from one of the following:

(i) The FEDVIP vision plan with the largest national enrollment that is offered to federal employees under 5 USC 8982; or

(ii) The benefits available under the State's separate CHIP plan, if a separate CHIP plan exists, to the eligibility group with the highest enrollment.

(c) *Supplementing the default base-benchmark plan.* A default base-benchmark plan as defined in §156.100(c) of this subpart that lacks any categories of essential health benefits will be supplemented by HHS in the following order, to the extent that any of the plans offer benefits in the missing EHB category:

(1) The largest plan by enrollment in the second largest product by enrollment in the State's small group market, as defined in §155.20 of this subchapter (except for pediatric oral and vision benefits);

(2) The largest plan by enrollment in the third largest product by enrollment in the State's small group market, as defined in §155.20 of this subchapter (except for pediatric oral and vision benefits);

(3) The largest national FEHBP plan by enrollment across States that is offered to federal employees under 5 USC 8903 (except for pediatric oral and vision benefits);

(4) The plan described in paragraph (b)(2)(i) of this section with respect to pediatric oral care benefits;

(5) The plan described in paragraph (b)(3)(i) of this section with respect to pediatric vision care benefits; and

(6) A habilitative benefit determined by the plan as described in §156.115(a)(5) of this subpart or by the State as described in paragraph (f) of this section.

(d) *Non-discrimination.* Not include discriminatory benefit designs that contravene the non-discrimination standards defined in §156.125 of this subpart.

(e) *Balance.* Ensure an appropriate balance among the EHB categories to ensure that benefits are not unduly weighted toward any category.

(f) *Determining habilitative services.* If the base-benchmark plan does not include coverage for habilitative services, the State may determine which services are included in that category.

**§ 156.115 Provision of EHB.**

(a) Provision of EHB means that a health plan provides benefits that—

(1) Are substantially equal to the EHB-benchmark plan including:

(i) Covered benefits;

(ii) Limitations on coverage including coverage of benefit amount, duration, and scope; and

(iii) Prescription drug benefits that meet the requirements of §156.122 of this subpart;

(2) With the exception of the EHB category of coverage for pediatric services, do not exclude an enrollee from coverage in an EHB category.

(3) With respect to the mental health and substance use disorder services, including behavioral health treatment services, required under §156.110(a)(5) of this subpart, comply with the requirements of §146.136 of this subchapter.

(4) Include preventive health services described in §147.130 of this subchapter.

(5) If the EHB-benchmark plan does not include coverage for habilitative services, as described in §156.110(f) of this subpart, include habilitative services in a manner that meets one of the following—

(i) Provides parity by covering habilitative services benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services; or

(ii) Is determined by the issuer and reported to HHS.

(b) Unless prohibited by applicable State requirements, an issuer of a plan offering EHB may substitute benefits if the issuer meets the following conditions—

(1) Substitutes a benefit that:

(i) Is actuarially equivalent to the benefit that is being replaced as determined in paragraph (b)(2) of this section;

(ii) Is made only within the same essential health benefit category; and

(iii) Is not a prescription drug benefit.

(2) Submits evidence of actuarial equivalence that is:

(i) Certified by a member of the American Academy of Actuaries;

(ii) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;

(iii) Based on a standardized plan population; and

(iv) Determined regardless of cost-sharing.

(c) A health plan does not fail to provide EHB solely because it does not